

This report presents a collection of papers on the past and present concepts of the hospital environment and the principles for establishing and carrying out control programs. It is Volume IV of a series of publications with the overall title, "Environmental Aspects of the Hospital," developed as a joint project of the Division of Hospital and Medical Facilities and the Division of Environmental Engineering and Food Protection (now the Environmental Sanitation Program of the National Center for Urban and Industrial Health) of the Public Health Service. The chapters in the series were prepared by authorities who have extensive experience in their specialities, with particular reference to medical facilities.

**ENVIRONMENTAL
ASPECTS
of the
HOSPITAL**

**volume IV
ADMINISTRATIVE
ASPECTS**

**U.S. DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE
Public Health Service**

**Division of Hospital and Medical Facilities
Washington, D.C. 20201**

Public Health Service Publication No. 980-C-18
August 1967

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402. Price 25 cents.

foreword

EXPANSION OF THE hospital in both size and function during the last two decades has made the problems of hospital environmental control more numerous and more complex.

This publication is the fourth in a series prepared as a guide for those at various administrative levels who are responsible for finding solutions to these problems. The volumes do not attempt to establish criteria to be uniformly followed in every hospital. Instead, they present the basic principles and practices, as seen by recognized authorities in the field, upon which an individual environmental control program can be built.

The Committee on Environmental Engineering Aspects of Hospitals and Medical Care Institutions, listed on the following page, served as the review and advisory group on the content of the series. Major credit for the publications is due Robert L. Schaeffer, Environmental Research Consultant, who served as project director and coordinated the work of the two Divisions.

The administrative aspects of environmental programs outlined in this publication are not inclusive of the total administrative process. This discussion is confined to an examination of the general principles, review of the philosophy and main considerations of voluntary standards, the highly significant but often nebulous relationships with health agencies, and a brief outline of the legal aspects of environmental control. Additional valuable information on hospital personnel programs can be obtained from a publication entitled *Hospital Personnel*, PHS Publication No. 930-C-9.



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GENERAL ADMINISTRATIVE ASPECTS OF ENVIRONMENTAL CONTROL

Robert L. Schaeffer

THIS BRIEF DISCUSSION of the administrative aspects of environmental control in hospitals will be confined to a survey of general principles, particularly as they relate to encouraging more effective use of nonmedical staff.

There is a vital interaction among the responsibilities of the governing board, administrator, and medical and nonmedical hospital staff. Success depends upon the accommodation of each one to the others. The most significant function of the administrator in improving the hospital environment, and indeed the one for which he is the most logical focus, is to promote greater unity of purpose and action between medical staff and employees. The various service department heads have a more direct, technical responsibility. They must manage their departments so as to contribute to the efficient maintenance and operation of the total physical plant. They have key roles in planning and design review for modifications or new construction. Department heads must mesh their own programs with those of other service departments whose operations help maintain a high level of environmental control in the hospital. A better understanding is necessary on the part of the administrator, board members, and medical staff of the critical role of the engineering, housekeeping, laundry, central service, and dietary employees in environmental control. Closer working relationships and better communications among these elements can certainly improve the quality of patient care.

Physician-administrators often carry their former values with them. These values may not include concern with environmental aspects of the hospital as long as necessary facilities and services are furnished when and how the physician requires

them and the fiscal affairs of the hospital are not significantly unbalanced in the process. Some administrators feel that financial management and community relations have far greater significance than improved plant operation and sanitation. This attitude, seldom modified by the viewpoints of medical staff or boards of directors, is the usual reason that more of the administrator's limited time is not devoted to working on environmental aspects with the hospital engineer, infection control officer, and chiefs of the housekeeping, dietary, central service, and laundry departments. Then, too, the competence level of some nonmedical hospital personnel has often discouraged both easy communication and full confidence in their efficiency.

Regardless of the reasons for inadequate administrative attention to hospital environmental controls, the role of the service departments is to control fire and safety hazards within the institution, and increase patient satisfaction.

With increased administrative-medical recognition comes improved efficiency achieved through better training and supervision. This in turn promotes greater tangible returns from the hospital's constantly increasing personnel costs. Improved patient and personnel safety from infections, accidents, and fires often leads to reduced liability and lower insurance premiums. Greater patient satisfaction results from a quieter, more comfortable, smoother running physical

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plant. These factors have a profound impact on the hospital's reputation among the population it serves.

GENERAL PRINCIPLES

The fundamentals of administration, whether applied in a hospital, industry, or government, serve only as guides for the department head. There is an overabundance of advice available, but the department executive, beset by a constant succession of problems, will employ the precepts personally tested in day-to-day operations.

Only a few principles constitute the foundation of administrative equipment. Any executive must know and thoroughly understand his objectives, whether established by himself or by others, and must make plans to reach them. He must organize and operate in reasonable accordance with these plans, modifying them if conditions change significantly. He must review and analyze progress to determine which procedures need changing and what phases of the operation require redirection within the planning framework. Underlying each of these principles are the three cardinal considerations of policy, money, and people. The ultimate factor of success for either the hospital administrator or department executive is the man himself—his viewpoints, insights, and capacity for dealing with others.

PLANNING

Setting Objectives for the Community

The hospital trustees, administrator and other principal staff members, and representatives of community agencies and government must evaluate hospital resources, determine what is needed, and set the stage for eventual accomplishment. Informed and imaginative participation by everyone concerned with the community hospital planning program is vital.

Just as the hospital building should conform architecturally to its physical site, it is equally important that the hospital relate properly to the community around it. No community institution exists in a vacuum, a hospital least of all. Urban

planning affects hospitals as it does other facilities and services. Influences such as highways, sewers, water supply, airports, urban renewal, and community disaster plans illustrate the relation of the hospital to the surrounding community.

The hospital department head should be aware of the broad factors regarding the hospital which must be considered in the community planning process, as well as his essential and proper place in that process. It is generally accepted by hospital planning specialists that both community and hospital planning require the carefully integrated efforts of a team. The hospital executive is an essential member of that team. He has a place not only in the planning and construction of physical improvements for his own hospital, but also in relating such improvements to the broad hospital needs of the community.

In the case of new hospital construction or expansion of an existing facility, a great number of general questions must be answered before any plans can be drawn. As a community institution, the hospital not only provides medical care service but also reflects the social and economic values of the community. The community impression of the hospital is based on varied factors such as rate structure, clientele, quality of medical staff, courtesy extended to patients and visitors, quality of the food, ease of access, and availability of parking space. Community acceptance of the hospital results from an overall evaluation of these factors.

Moreover, in recent years the design of hospitals has been undergoing revolutionary change. There is a growing recognition that the hospital setting affects the general well-being and emotional state of patients, and that it is no longer sufficient to design facilities primarily with convenience in mind. Location, setting, size, spatial arrangements, construction materials, and color harmony are all important and should be kept constantly in mind during the planning process.

The general subject of hospital planning is covered well in several texts.^{1 2} Such manuals present comprehensive guides for the planning, organization, and financing of new hospitals and for the development of interrelationships among them to effectively meet community health needs. However, these texts do not adequately establish the role of the hospital executive nor suggest how to take advantage of his skills in

sufficient degree. Too often the task of hospital planning is left entirely to an architectural consultant who may deal with this vital function on an ad hoc basis. The hospital engineer, for example, should be a continuing staff planner and serve as the primary construction coordinator for his institution. He is also the logical individual to conduct a site study. Just as the basic objective in an industrial plant location is to find the one site which permits the lowest costs to produce maximum profits from the company's operations, common sense demands the same type of location study for a hospital. In many cases, of course, such a study is conducted by qualified outside consultants. However, there are some instances in which no thorough analysis is made at all and hospital location is determined on the basis of a few off-hand impressions from a hurried site tour, by the whim of some hospital board members, or by local political pressures.

Internal Planning

The hospital executive should allow time for internal planning and policy-making discussions with his superiors, staff, and other department heads. If he attempts to plan and organize as he goes along, his days will be spent in action with no time left for the speculation and discussion that give action a direction and purpose. The results of planning sessions form the bases on which the operating program is guided and evaluated, and thorough and imaginative planning largely determines operating effectiveness.

The internal budgetary process deserves particular consideration. A review of present and anticipated financial needs is necessary to accurately define short-term maintenance and service programs as well as to establish and modify phases of long-range plans. Estimated program costs determine the assigning of priorities among competing needs. In this area arise some of the most important decisions in which the hospital department head plays a dominant part, for his accurate assessment of what is truly urgent and his subsequent recommendations to the hospital administrator determine much of the short-and long-term success in operating the hospital with efficiency and economy.

As a hypothetical illustration of how long-range fiscal policies may be defined by governing bodies and transmitted through the administrator

to department heads, a sample memo used in a hospital budgeting text follows:

To refresh your memory, there follows an excerpt from Policy Letter No. 3, which states the long-range financial policy adopted by the Finance and Executive Committees of the Board of Trustees in furtherance of their effort to curtail depletion of capital resources:

1. There should not be any expansion of facilities or operations unless new money is available for the cost of the new facility plus sufficient additional money for its maintenance.
2. There should be no improvements in present facilities unless the project is self-liquidating in a short period of time (e.g., 5 years) through increase in income or by reduction of expense.
3. There should be a limitation on purchase of new equipment or replacements; the limitation to be determined by the amount of depreciation on fixtures and equipment included in the income statement.
4. There should be a stricter adherence to individual department expense budgets as prepared at the beginning of the year and approved by the Board of Governors.
5. A concerted effort should be made during the next few years to eliminate the deficit of the hospital.

Work Preliminary to Preparation of Budget

In undertaking studies preliminary to the preparation of your budget you are urged to take into your confidence those who are immediately responsible to you for the operation

requests provide for nothing but essential and vital patient services.

3. To evaluate carefully the work of each employee. Free use should be made of the . . . [personnel] appraisal system. Where individual performance does not reach acceptable standards, the Employment Manager in the Personnel Department should be notified to be on the alert for a replacement.³

The above example is typical of what the hospital department head may receive on an annual or other periodic basis. As hospital capital and operating costs increase, it becomes apparent that technical expertise alone is not the only measure of an executive's value to the hospital. He must be an administrator and manager; and to function effectively in this regard he should not adopt the attitude of some "old line" department heads whose jobs were both simpler and less important than they are today and who often reacted resentfully to administrative requirements and requests. The department head should appreciate that the hospital administrator, although often aware of physical plant and operating requirements and their significance, must keep the hospital solvent by constantly seeking more efficient and economical procedures and more effective use of equipment and personnel in every area. The administrator, in turn, has sometimes not taken the trouble—and study—to acquire a knowledge of the significance of service department functions. He has sometimes failed to recognize the probable consequences, in terms of lowered patient care quality, of failing to adequately support the nonmedical department programs in matters of genuine priority. As between any two professionals of different disciplines, a sincere mutual effort is needed to appreciate each other's viewpoints and problems and thereby establish some common ground for working out the best solution.

After relative priorities have been determined for the coming year, the allocation of available funds and estimates of spending schedules can be made. In some instances, operation allocations are made to departments or services and their administration given to department heads. However, various modifications of this pattern are common. A department head may be allocated a yearly budget broken into quarterly allotments, thereby estimating in rough fashion what the spending schedule may be. He may be given an annual expenditure ceiling but may have to re-

quest all purchases or contracts above a certain cost through the administrator or hospital purchasing agent.

In the area of budget execution, it is paramount to realize that the entire process, however well planned, is a dynamic one. Particularly in matters affecting the physical plant, contingencies will arise which will have a pronounced effect on carefully drawn plans for scheduled spending and financial management. The financial plan must provide contingency funds, based on experience or a "best-guess" formula, and provision must be made for departments to justify unexpected expenditures at variance with estimated spending schedules.

Finally, good financial control depends largely on establishment of an adequate reporting system. Good reports—which means necessary ones—enable executives to keep some account of what is being accomplished by their departments in proportion to the level of expenditures.

ORGANIZATION

When objectives have been determined and planning accomplished, organizing and staffing in accordance with planning provisions follow. In all departments, determination of position requirements and assignment of the best qualified individuals available should follow the general pattern of maintaining as narrow a span of supervisory control as practical. Designating too many individuals as supervisors invites conflict and the "all chiefs and no Indians" situations which may result. Having too few supervisors, on the other hand, increases the likelihood of slackness and indifference to work quality among workers. The calibre of workers in the local labor market will determine how much can be left to individual initiative. The team concept in some engineering and maintenance areas may serve as a practical means of reducing a large work force to smaller units, with occasional rotation of responsibilities to promote wider experience for individual workers.

Authority to match assigned responsibilities must be delegated. An individual responsible for accomplishing a given level of results must have the necessary prerogatives in directing his subordinates. He should have complete freedom in

requesting the assistance of other hospital elements at the same administrative level as his own. In addition, he should be given free and frequent access to his immediate supervisor for information and consultation. The need for specific information is usually not as important as the availability of easy communication both upward and downward in the organizational structure. The informal organization structure in which individuals or elements are bypassed because "he always gives me a hard time," or "they never get it done," is perpetuated and intensified by poor communications.

One of the most frequently encountered administrative shortcomings among members of any profession is the reluctance to delegate. This is particularly prevalent among department heads who begin with relatively small organizations that lend themselves to personal management. What starts as an understandable need to be kept informed regarding the total operation evolves through expansion into a serious bottleneck created by failure to realize the impossibility of having every decision, request, and piece of correspondence sent across one executive's desk. As an organization and its functions expand, the successful department head must delegate more of the operating decisions and functions to his staff and preserve his basic role as the executive making fundamental decisions on planning, work programming, budget, and personnel matters.

The executive's primary need is to be able to rely on the competence of his supervisory staff in areas with which he is not in constant contact, while encouraging them to gain more knowledge so as to better direct staff efforts. The problem reflects the importance of recruiting qualified individuals in whom he may place such confidence and increasing their skills with supplementary training in new techniques.

Reporting

In the administration of any enterprise, including hospitals, there persists a tendency toward over-reporting. The wasted manhours, irritation, and sidetracking of worthwhile effort through filling out unnecessary reports cannot be over-emphasized. Sound analysis to determine the essential information needed to properly manage the hospital or any of its departments should be carried out by administrative staff in discussion

with department heads, and then reporting systems should be established to deliver this genuinely necessary data. The type of system is largely determined by frequency of use, required timeliness of information, significance in measuring actual performance, or by the role of the information in long-range planning.

Acquisition cost, physical space and worktime to operate the system, and flexibility for expansion must be carefully evaluated to determine any information or record system's utility for either the administrator or department head.

OPERATION

During daily operations the hospital executive uses all elements of the total administrative process. He reassesses planning, constantly evaluates departmental policies and procedures in light of daily experience, and reviews and analyzes his total program through personal contacts with other staff members, patients, and members of the community. The efficiency of hospital department operations depends in large part on the effectiveness of the planning, policy making, and organizing which precede them. Under operating conditions, a procedure that functions well carries its own title to recognition, and the procedures upon which the department head depends are those he has found successful in his own experience. The more details of the principles he tries to employ, the less is his flexibility to meet emergencies and special situations.

often not as accurately reflected by the presence or absence of complaints as by what the executive hears from patients and staff during informal rounds. The comments of department heads, first-line supervisors, staff, and patients play a vital part in reflecting the actual performance of an institution. There is naturally some degree of bias and self-interest mixed with any statements of troublesome situations. Where well-designed record systems are used, the records may reflect a different picture than the individual verbal complaints regarding such familiar questions as the time lapse between requesting and receiving service and equipment replacement or installation orders. In budget management, methods improvement, and personnel work involving time studies, job descriptions, time and attendance records, sick leave reports, and performance evaluations, the department head must have close and productive liaison with the administrator. As previously mentioned, the administrator should consult department heads to determine what records will be needed apart from such routine material as engineering maintenance files to enable him and them to analyze progress and to provide adequate facts for proposed budget or staff changes. Few department heads will voluntarily embark on such time-consuming efforts as conducting time or method studies, although they may be necessary to justify expansion of facilities, purchase of new equipment, or changes in staffing patterns as well as for comparison with similar institutions in different areas. Such studies are, therefore, often handled centrally by the administrative office and require a close working relationship between service department heads and the administrator.

The review and analysis procedure, through both records and informal sources, provides excellent background for better communication

among department executive, administrator, and the board. The complaint of technical people that the administration does not understand their problems, and sometimes does not want to understand them, may be resolved when factual evidence of actual performance is available to the administration for use in making decisions and establishing procedures.

SUMMARY

In general, the hospital department executive finds that the four major functions discussed in this chapter constitute his basic tools to handle a most demanding task. The physical complexity of the modern hospital, its organizational structure, anxieties and tensions associated with illness and its care, the enormous number of individuals and groups in the hospital with problems they feel demand his personal attention, combine to insure a high degree of unpredictability in the department head's workday.

The individual suited to head a hospital service department must possess technical competence, both in breadth and depth, administrative ability, persistence, tact, patience, and empathy, all in unusual degree. It has been rightly said that such a person helps to run a small city and must supply a shelter with unique environmental controls and uninterrupted utilities. He must deal with mechanical, electrical, medical, and safety-related emergencies that are often quite literally matters of life or death. He functions in an institution that has grown prodigiously in complexity of structure and service and in its capital and operating costs. He must be both a first-rate technician and an adept manager to fulfill his role as chief of a hospital nonmedical staff service.

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VOLUNTARY STANDARDS

Sam O. Gilmer, Jr.

A STANDARD does not necessarily represent the ideal. It may reflect only what legally constituted authoritative bodies deem to be in the public welfare and what is reasonably attainable in light of generally accepted competencies, methods, and resources. Interpreted in another manner, a standard might be termed a measure of quality either established on a voluntary basis by those subject to it or imposed upon them by legal authority.

In reviewing the hierarchy of standards, the most obvious are the "mandatory" provisions made by regulatory bodies which also issue "recommendations." Generally, recommendations are intended to be only a shade less emphatic than those provisions labeled mandatory. Then come the "suggestions" of some enforcement agencies. Such suggestions may be offered gratuitously or may be in response to requests for advice on the part of the institutional operators. These requests usually reflect management's aspirations toward self-education and self-appraisal and may follow a consultant's evaluation of institutional resources. Also, they may result from an unscheduled inspection by an official agency invited to review principles, standards, policies, methods, and competencies by the institution wishing to exceed minimum standards.

STANDARDS AND REGULATIONS

How does a standard differ from a regulation? Basically, a regulation cannot be established until after a standard is determined. Standards may exist without either governmentally or institutionally published regulations. The standard may be

presented in several degrees of intensity: *mandatory*, in that the institution cannot operate at all unless it is observed; *required*, measures necessary for efficient operation, and *voluntary*, considered desirable for a continuous, acceptable level of operation or for the improvement of service.

The governmentally imposed regulation based upon law usually reflects a minimum standard, hopefully the starting point for development of an individual body of standards by an institution. Thus, governmental regulations are those legally prescribed by various local and State governments and enforced through scheduled and spot inspections of the premises concerned.

Mandatory and Voluntary

At the Federal level, except for those medical care institutions and facilities operated exclusively by the Federal government, there are few mandatory standards affecting the operation of civilian hospitals. Exceptions include standards for control of narcotics, purchase of tax-free alcohol, and construction of facilities receiving Federal grant-in-aid funds. Most mandatory hospital regulations lie within the jurisdiction of State and local authorities and are expressed through standards which constitute the basis of laws and regulations.

Considerable variance exists among the many governmentally issued directives and recommendations. The following examples have been chosen as illustrative because they have similar "voluntary" counterparts (e.g., the Standards of

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the Joint Commission on Accreditation of Hospitals):

Dietary Services

Food and foodstuffs at hospitals shall be stored, handled and served in compliance with the provisions of Section 24:15-1 to 12, New Jersey Revised Statutes and the regulations adopted thereunder and shall be in compliance with sanitary requirements of the local Board of Health pertaining to restaurants (New Jersey).

Physical Plant

All hospital buildings used for patients shall be maintained in a condition of good repair and be of a type of construction which is in conformity with all existing local and State building, heating, electric, and plumbing codes (Massachusetts).

Fire Safety

All hospitals shall conform to the rules and regulations adopted by the State Fire Marshal establishing minimum standards for the prevention of fire and for the protection of life and property against fire and panic. All hospitals shall secure and maintain a clearance relative to fire safety from the State Fire Marshal (California).

Radiological Services

X-ray equipment, when permitted in operating rooms, shall be provided with an approved method of eliminating electrostatic accumulation. All control devices and switches for X-ray equipment shall conform to the requirements of the National Fire Protection Association (Massachusetts).

Isolation Facilities

The following isolation facilities for a suspect or diagnosed communicable disease shall be provided:

- a. Hand-washing facilities with knee, elbow or foot type mixing faucets within the isolation room.
- b. Individual toilet facilities within the isolation room.
- c. Contaminated dishes and utility services shall be kept distinctly separated until sterilized.
- d. Gown racks shall be provided within the isolation room.
- e. Medical aseptic procedures shall be fol-

lowed. Refer to communicable disease hospital standards (Colorado).

All hospitals should familiarize themselves with their State and local licensure laws, ordinances, rules, and regulations. The hospital's legal counsel should be consulted in this regard, for when a State charter and/or license to operate a hospital is obtained, the institution becomes subject to the laws and regulations of appropriate State, local, and Federal agencies. The hospital engineer and other department heads should request that the administrator have the hospital's legal counsel determine which regulations are applicable to their activities.

The voluntary standard is always supplementary to the mandatory one, and it constitutes one of the more certain indices of the institution's desire to serve its clientele to the best of its ability. Governmental regulations on any level may point toward the ideal, but they generally proclaim only minimum standards. In contrast, the voluntary standard should serve to stimulate the operator toward the highest possible level of service. In one sense, all standards are voluntary. Without the continuous presence of a representative of the regulatory agency or agencies, almost any governmentally imposed standard might conceivably be circumvented by the determined operator who is not fully convinced of its real value to him and to those he serves.

The basis for excellent voluntary standards, as well as for enthusiastic compliance with those that are mandatory, is always the attitude of the institution's governing body. This is certainly as true of environmental standards as it is of those pertaining to the general level of medical and nursing care rendered by the hospital. In addition, the wise administrator seeks to convey to his subordinates and his governing body the need for maximum development of voluntary standards as well as for compliance with those which are mandatory.

In turn, the governing body desiring excellence is obliged to support its administrative representatives in their efforts toward the attainment of this objective. Of even more importance, such a governing body will give maximum support to the administration which seeks through education, evaluation, and continuous reappraisal the establishment of standards which approach the ideal.

In developing standards it is necessary to consider the effect, often overlooked, that a too

ambitious standard proclaimed for one activity may have upon an interrelated activity within another department, the finances of the institution, or the morale of those who serve it. For example, one could conceive such high standards for the dietary service as to preclude efficient operation of one of the other clinically supportive services, such as housekeeping, because of diversion of personnel and financial support. Thus, the total body of standards, mandatory and voluntary, must be in harmony with the total objectives of the institution. This is the burden of administration, and it must be borne by all concerned.

Personnel Training

One significant problem in most institutions is the tendency for rank and file employees to go their separate ways unless concerted effort is made to make them *want* to observe high standards in work performance and to maintain a continuously improving level of efficiency. This can be achieved only when authority establishes an educational program of some depth for all personnel. A superficial approach, such as the training program whose target is only cost reduction, will probably fail. On the other hand, a training program that recognizes the worth of the individual and is guided by a sincere desire to help him improve himself and to gain real job satisfaction will succeed. It will succeed because it will convey to the employee the *reason* for observing prescribed standards and, if personnel selection techniques have been based upon sound administration principles, the individual employee will believe that he is making a contribution to society and to his own self-respect. Most people respond better to such an approach. This principle applies particularly to sanitation and safety.

Training programs may be both intramural and extramural and, in fact, can precede actual employment in that an arrangement may be made with appropriate governmental, quasi-governmental, and selected educational institutions for pre-employment training of selected categories of personnel. Reference and text material should include the previously mentioned State, local, and Federal laws, ordinances, rules, and regulations, together with the standards and recommendations composed by the several approving and accrediting agencies, such as the Joint Commission on Accreditation of Hospitals.

Recommendations such as the Joint Commission standards, although voluntarily accepted by the institution, must be complied with if the hospital is to be recognized. The institution, of course, is not compelled to seek such certification.

STANDARDS OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

The Commission conducts an inspection and accreditation program to encourage physicians and hospitals to voluntarily apply basic principles of organization and administration leading to better, more efficient patient care. It seeks to promote medical and hospital care of the highest order and maintenance of essential diagnostic and therapeutic services in the hospital through the coordinated effort of the medical staff and governing body.

A Commission statement on the problems of hospital-acquired infections, if slightly paraphrased, is applicable to the entire field of hospital standards. It noted that any machine or equipment is only as good as the individual using it. All the rules, regulations, and controls mean nothing if hospital personnel do not constantly check themselves for human errors. Continuing education and constant vigilance to the cause, effect, and elimination of dangers to the patient and those who attend him, together with the application of proper control methods, are of prime importance.

The role of the Joint Commission on Accreditation of Hospitals cannot be overemphasized in a discussion of voluntary standards. Hence, most of the Commission's current standards relating to the general field of environmental engineering are summarized in the remainder of this chapter.

Dietary Services

The Joint Commission makes a number of references to food service in the hospital seeking accreditation. Not only does it hold as one of its standards that sanitary conditions must be maintained in the storage, preparation, and distribution of food, but also it asks its surveyors to ascertain that there are satisfactory methods for transporting food and for refrigeration, dish-

washing, and refuse disposal. The Commission has commented in its *Bulletin*:

It is the opinion of the Joint Commission that this department should be under the supervision of a qualified dietitian (preferably a member of the American Dietetic Association) on a full-time basis if possible or in smaller hospitals on a consultative part-time basis. There should be facilities for preparing therapeutic diets, although this does not necessarily require a special diet kitchen. In visiting a hospital, the surveyor evaluates this department on the basis of cleanliness, proper and adequate refrigeration, dishwashing and garbage disposal facilities, safe practices in the preparation and transportation of food, and the controls established to insure proper diet therapy. The commonest faults reported by surveyors are listed:

1. Lack of thermometers and temperature controls in large refrigerators.
2. Lack of temperature and thermostatic controls on dishwashing apparatus, or non-utilization when present. Hand drying of dishes.
3. Poor and unsanitary garbage control and disposal.
4. Storage of uncovered food in the same refrigerator with drugs.
5. Failure to clean ice storage bins. This is quite frequently found.
6. Presence of unimaginative, unpalatable, repetitious, stereotyped special diets.
7. Poor housekeeping and sanitation in the department.
8. Personnel uninstructed in the handling, presentation and disposal of food.
9. Poor transportation of food, resulting in cold, unpalatable food.¹

In regard to dish cleaning and the cleaning of other dietary services equipment, the Commission has said:

Rules and regulations for the temperature control of wash and rinse water in dishwashing machines vary with municipal and State boards of health codes. Check your local authorities. The following excerpt from the *Minimum Standards of Hospital Maintenance and Operation* published by the Illinois Department of Public Health is included as a guide: "In

dishwashing machines the use of high wash water temperatures, higher detergent concentrations, and the more efficient mechanical removal of soil make it possible to employ a shorter exposure period. (1) The washing period shall be at least 40 seconds with the wash water temperature at 120° F. to 140° F. (2) The rinse period shall be at least 20 seconds with the rinse water temperature at 170° F. or higher.

"Dishwashing machines must be kept clean. The pumps and the wash and rinse sprays or jets, if any, should be so designed that a forceful stream of water will reach all of the utensils when they are properly racked. Periodic inspection and cleaning of wash and rinse sprays are essential to continued satisfactory operation, and these parts of the machine should, therefore, be readily accessible for inspection and cleaning. The wash-tank water should be changed during operation as often as is found necessary to keep it reasonably clean. An effective concentration of detergent should be maintained at all times.

"It is recommended that new dishwashing machines be provided with (a) properly operating, automatic detergent dispenser, (b) thermostatic control of the temperature of the wash water as well as that of the rinse water, and (c) thermometers in both the wash and rinse water lines and in such a location as to be readily visible. Adequate hot water heating and storage facilities are essential."²

The Commission, in referring to the physical plant facilities of the hospital undergoing survey in anticipation of accreditation, holds as a basic principle that the hospital buildings must be constructed, arranged, and maintained to insure the safety of the patient; and must provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

No other JCAH principle exists which explicitly refers to physical plant sanitation and safety. However, in listing standards which it sets in this area, we find the Commission requesting the following:

The buildings of the hospital must be solidly constructed with adequate space and safeguards for each patient. Space provided shall not be less than required by existing legal codes. The hospital shall provide:

1. Fire protection by installation of rigid controls and written fire control plans, the elimination of fire hazards, the installation of necessary safeguards such as extinguishers, sprinkling devices, fire barriers, etc., to insure rapid and effective fire control.

2. A sanitary environment to avoid sources and transmission of infections.

3. Facilities for isolation of patients with communicable diseases, especially in obstetrical, newborn and pediatric sections.

4. Emergency lighting in operating, delivery and emergency rooms, nursery and stairwells.

5. Adequate diagnostic and therapeutic facilities.³

The Commission requests of the hospital certain physical plant information prior to the conduct of the accreditation survey, including:

1. Dates buildings were constructed.

2. Facilities for segregation of patients by service.

3. Isolation service facilities (i.e., a private room with separate toilet facilities, and written care procedures); and

4. The percentage of occupancy.

When the Commission's surveyor visits the hospital, he also checks the standard of maintenance and housekeeping, any problems of bed spacing or other features of overcrowding, as well as the emergency lighting facilities. In connection with the last item, the Commission says:

Emergency power and light facilities are required in every hospital. The lives of patients are at stake and no hospital should gamble, even though the need for these facilities has never arisen. Cyclones, tornadoes, floods and storms are not predictable nor are their courses. The hospital must be prepared just in case.⁴

Fire Safety

The Commission's surveyors also check the construction of the buildings in relation to fire resistance, as well as fire protection plans and devices, such as extinguishers, written plans, fire drills, and sprinkler systems. Officially, this appears to constitute the stand of the Commission in regard to safety. However, the literature indicates that the Commission's surveyors go into this area in some depth. The following is from

correspondence received and answered by the Commission:

What are the chief fire hazards found by surveyors of the Joint Commission on Accreditation of Hospitals? The Commission, in replying, stated:

Fire hazards are reported all too frequently. Evidently in many institutions much emphasis is placed on concrete and steel. No structure is fireproof if the contents are combustible, and a strong exterior will not prevent a holocaust in the interior.

Sprinkler systems are recommended in all nonfire-resistant buildings and areas, including store rooms, paint shops, laundry chutes, elevator shafts and attics. Fire extinguishers, sufficient in number and type and strategically placed, should be checked annually and the date so recorded on the tag. Extinguishers are useless if they are empty, firmly and immovably entrenched in their brackets, or too heavy and too high for practical use.

Stairwells are to be enclosed, and the doors leading to the stairs kept closed at all times. Unused shafts, such as dumbwaiters that are no longer in service, should be permanently sealed.

Operating room hazards should be minimized by proper grounding facilities, preferably conductive flooring augmented by conductive shoes and clothing on personnel. Drag chains are not considered very effective as often they are not cleaned and sometimes do not touch the floor. All switches, sockets and plugs should be explosion proof, including those on fans, heaters and suction machines. Faulty storage of anesthetic gases is to be avoided and reference should be made to the following pamphlets: National Fire Protection Association No. 565-

interval should be utilized by the hospital for the fire marshal's inspection and report. Many problems arise in the fire prevention program and much assistance may be obtained from the National Safety Council, Chicago, or the American Hospital Association, Chicago.

No hospital, regardless of the excellence of the medical care afforded, can be accredited if the potential fire hazards within the building endanger the patients.⁵

Prior to its surveyor's visit, the Commission asks that the hospital seeking accreditation list the precautions it takes to deal with possible explosion and fire hazards in the operating suite. These include references to the shockproof and sparkproof status of equipment and humidity controls and proper grounding of equipment, as well as a statement as to the use of electrocautery equipment in the presence of explosive gases. Also included are provisions for the posting of safety regulations and a question as to whether personnel are governed by express regulations regarding safety in this area. As to the storage of anesthetic gases, the Commission offers the following:

Anesthetic gases should be stored in a vented room. All upright cylinders should be chained or strapped so they cannot fall. Oxygen cylinders and cylinders of cyclopropane or ethylene should not be stored in the same room.

Every hospital administrator, hospital engineer, operating room supervisor and anesthetist should have a copy of the manual, "Code for Use of Flammable Anesthetics (Safe Practice for Hospital Operating Rooms)," and know its contents. The manual is available at 25 cents per copy from the National Fire Protection Association, 60 Batterymarch Street, Boston, Mass. 02110.⁶

Radiological Services

The Joint Commission on Accreditation of Hospitals in its Standards requires that the radiology department be free of hazards to patients and personnel. The hospital must certify that:

- a. The equipment is shockproof.
- b. The department is protected by the usual safety measures.

- c. The personnel is checked periodically by blood counts and exposure tests.⁷

The Commission's surveyor, upon visiting the hospital, is asked to ascertain whether monitoring devices are used to detect radiation hazards to personnel and patients.

In further reference to safety in this department, the Joint Commission *Bulletin* has noted:

Because of the special hazards encountered in the usage of fluoroscopes, radium and isotopes, recommendations emanating from the American Medical Association, the American College of Radiology and the American Hospital Association and approved by the Commissioners of the Joint Commission on Accreditation of Hospitals, have been synopsized below for guidance and information purposes.

1. Fluoroscopes and radiographs

a. The use of fluoroscopes and radiographs in the department of radiology in institutions should be limited to members of the staff—either medical or lay—who have been designated as qualified by the radiologist or roentgenologist, and the use of fluoroscopes and radiographs in departments or divisions other than the department of radiology should be limited to members of the staff—either medical or lay—who have been designated as qualified by the radiologist or roentgenologist or an appropriately constituted committee.

b. A special sheet should be included in all hospital and clinic charts for data of fluoroscopic examinations specifying date, site, roentgens per minute, exposure time and operator.

c. All institutions should be requested to use timers on all fluoroscopes.

2. Radioactive elements

a. The use of radium element and its disintegration products, as well as radioactive isotopes, shall be under the supervision of a physician with certification, or its equivalent, in radiology or therapeutic radiology.

b. No one shall be permitted to use radium element and its disintegration products, or radioactive isotopes, unless he has been designated as qualified by the radiologist or an appropriately constituted committee.

c. Regulations shall be established, on the recommendation of the medical staff, as to the

administration of the application and removal of these materials.

d. Ideally, a department having a supply of radium element and its disintegration products, as well as radioactive isotopes, should have a physicist qualified in radiation physics by the Board of Radiology, preferably as a full-time member of the department; such a physicist to be available in consultation for dosage problems involving radium as well as responsible for the safe housing of radioactive isotopes, the protection of patient and personnel, and the disposal of waste products.⁸

Use of Antibiotics

The medical profession has become increasingly aware of the problems created by the routine and indiscriminate use of antibiotics. Hospital surveys by the Joint Commission reveal that the infection rate in most hospitals routinely using antibiotics is higher than in those not doing so. One common factor in hospital infections appears to be the resistance of bacteria to antibiotics used on the individual case. From this, the conclusion can be drawn that an increase in infections may be stimulated by the routine, indiscriminate use of preventive antibiotics in the absence of infection or such indiscriminate use in the presence of infection without preceding diagnostic cultures and sensitivity tests. In the latter case, use of the wrong antibiotic can be positively harmful since the therapy only inhibits the infectious agent and at the same time stimulates the growth of resistant strains of other organisms which may become pathogenic in their turn.

Infectious Diseases

While the *Standards* of the Joint Commission do not elaborate upon the problem of infection control, its *Bulletin* has devoted considerable space to the problem. Some excerpts from the *Bulletin* dealing with this important topic follow:

1. Committee on Infections

The Commissioners recommend that every hospital have an "Infection Committee" charged with the responsibility of investigation, control and prevention of infections within hospitals. Membership on this committee

should include the medical staff, administration and nursing service personnel. Where possible, participation with community health organizations such as health departments, medical societies and hospital councils is recommended, because the problem is not necessarily confined to the hospital itself. The responsibility of the committee can appropriately include the following:

a. Establishment of definite controls. Control measures must have validity.

b. Establishment of techniques for discovering infections in patients who have left the hospital:

(1) Trace source of infection for which a patient may be admitted.

(2) Periodic sampling by letter, card, call or visit of discharged patients.

c. Make certain that bacteriologic services in or out of the hospital are available.

d. Establish a system of reporting all infections among patients and personnel and keep records as a basis for studying the source of infections.

2. Review of Existing Practices

a. Clean and aseptic techniques should be practiced on all services of every hospital at all times. This includes the following procedures involved in patient care:

(1) Recheck all dietary and food handling procedures, such as proper dishwashing techniques, preparation and disposal of food, refrigeration, sanitation of ice bins, and the disinfection of contaminated utensils and equipment. There should be a special technique for infected or "isolation" patients.

like utility rooms, janitors' closets, trash closets, etc.

(5) Check sources of air pollution. Air conditioning and ventilating units should be inspected regularly for contamination through intake sources, screens and filters (wet or dry). Hospital floors and corridors must be considered as potential spreaders of infection. Wet mopping is far preferable to dry sweeping. There should be a definite practice established for the care and cleanliness of the mop after each usage; a dirty mop spreads infection.

(6)(a) Routine periodic culturing of autoclaves and water sterilizers, which is a must for all hospitals.

(b) Educate and orient all personnel in the practice of aseptic techniques. An informed worker is a better and a safer worker. It is especially important that physicians not consider themselves the exception to the rule, but both teach and set a good example for all. There can be only one accepted standard of practice. The following practices are some which should be studied:

1) Handwashing and scrubbing practices with review of proper soaps and detergents. Sinks with foot or knee controls in operating rooms, nurseries and isolation rooms are especially vital.

2) Proper gown techniques.

3) Proper mask techniques.

4) Proper dressing cart techniques and procedures.

5) Proper packaging of all goods, materials and instruments for steam sterilization.

6) Proper packing of autoclaves. No autoclave should be so tightly packed that the packages are either tight together or tightly pressed against the walls. It is especially important that all impervious containers such as cans, jars, test tubes and deep trays be so placed in the autoclave that they lie on their sides, or with the opening downward, which prevents the trapping of air and failure of sterilization at the bottom of the container. Improper packaging and improper packing by unskilled people can undo the finest autoclave precautions.⁹

The recognition and elimination of infections in patients and personnel are thought by many to be the most important single facet in infection con-

trol. No hospital employee with a carbuncle, boil, acne, paronychia, fungus infection, upper respiratory infection, diarrhea, common cold, or, in fact, any infection, should be allowed in contact with patients. The reverse is true of infected patients. One of the commonest oversights by the physician is not notifying the admitting office of the presence of infection in a patient, or by the admitting office or floor nurse not recognizing its obvious presence on admittance.

There is no single factor responsible for so-called hospital infections. There are many factors and causes and each should be investigated. The Joint Commission does not have literature on special techniques and treatments. Medical and hospital library indexes should be consulted for specific articles.

The Commission, in referring to the operation of autoclaves, noted:

Cultures on sterilizers and autoclaves should be taken at least once a month. If there is evidence of infection, cultures should be taken frequently until the cause of the infection is determined and eliminated.

The suggested procedure for bacteriological testing of autoclaves and the sterility of autoclaved goods is outlined on pages 84-87 of the American Hospital Association's *Surgical Technical Aide Instructor's Manual*. These procedures or modifications of them should be used. The pathologist should be consulted in working out the procedure.¹⁰

Similarly, when questioned as to the desirability of a recording thermometer on the discharge lines of sterilizers, the Commission held that:

When properly installed and used, the recording thermometer is one of several tools that can be used to detect faulty sterilization technique. It does indicate the same temperature as shown on the indicating thermometer in the discharge system of the sterilizing chamber. It does record the duration of each exposure. Lacking the recorder, the operator might forget to time the exposure when the thermometer has advanced to the temperature prescribed. Without the recorder, it is difficult to maintain the required uniformity when several individuals have access to the sterilizers, or to prove what has or has not been done. It is important to be able to prove, with daily chart records, that definite standards of time and temperature have been maintained.

The use of monthly culture tests is a mandatory requirement for determining efficiency of sterilization. It does not mean that all other precautions should be abandoned. In addition to culture tests, hospitals should continue to use other means of evaluation, such as automatic controls, color indicators and fusion tubes. The shortcomings of these devices should be kept in mind, however. Personnel efficiency

and supervision are very important. All the mechanical controls in the world mean very little unless there is strict adherence to proper packaging and loading of sterilizers. "

In summary, standards provide the necessary groundwork for the application of those principles which, in their aggregate, have proved effective in controlling hospital-acquired infections and in preventing accidents among the hospital population.

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RELATIONSHIPS WITH HEALTH AGENCIES

Franklin H. Fiske, Vinson R. Oviatt, Russell B. Watson, M.D.

HEALTH DEPARTMENTS are organized to protect the citizens within their jurisdiction from disease and injury. In preventing disease transmission, the control of environmental health factors is an integral part of the community health program. Hospitals are the essential facilities in this program, not only meeting the need for diagnosis and treatment of disease and injury, but, in a broader sense, serving as the center for the specialized skills and practice of the healing arts. The hospital should, and does in many community situations, provide a focal point for most community health services. To make the best use of this focus, an effective working relationship must be established and maintained between hospitals and health agency personnel.

HOSPITAL AND HEALTH AGENCY COOPERATION

Improved relationships between hospitals and health agencies would be beneficial to the programs of both participants in better protecting the community as a whole. Dr. Myron Wegman has said:

We have witnessed, in the rise of public health in the United States, enormous advances in the field of environmental sanitation and in community measures for the prevention of communicable disease, but we have seen little if any participation by health departments

in regard to provision of medical care for the ill.¹

In many instances, local health departments have failed to establish effective relationships in the area of medical care. Throughout the Nation, most large cities and many counties have established full-time health departments which strive to establish and maintain a safe environment and reasonable protection from health hazards. Although the extent of relationship to the hospital and other aspects of medical care has been conspicuously limited, some progress has been made in areas such as food sanitation and radiation safety programs.

The reluctance of the medical profession, and through it of the hospital, to participate in environmental health programs was for a long time reinforced by several factors:

1. Until the past twenty years, the hospital was not as architecturally and mechanically complex as are modern institutions and required less specialization in both its medical and service staff.
2. There was no acute, highly publicized awareness of hospital-acquired infections. This may be due to the comparatively recent rise of antibiotic-resistant pathogens, some decline in hospital sanitation occasioned by wartime and early post-

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war personnel shortages, faulty reporting of infections—a shortcoming still very much in evidence—or a combination of all these and other factors.

3. Health agencies lacked trained personnel to furnish consultation and assistance to the hospital. Physicians, nurses, engineers, and sanitarians were trained principally in how to detect and combat food and water borne disease, as well as "traditional" communicable ailments such as tuberculosis and venereal infections. The more specialized techniques that have been developed to control hospital infections were not part of the average public health worker's equipment.

4. Perhaps most important of all, few health agency people had—or now have—comprehensive experience in hospitals. Aside from specific technical skills, this involves a knowledge of standard hospital procedures as well as a feeling for the climate and organization of the hospital. In blunt terms, it involves the knowledge of *who* to approach and *how* in order to gain and maintain a place in hospital programs.

Health departments that have developed the requisite hospital environmental skills and the relationships within which to use them have basic functions to perform. A recent text summarized them well:

In essence, one can separate out two major functions of the health department in relation to hospitals. The first . . . is that of promoting close working relationships and stimulating hospitals to participate in community health activities. In performing this function, the health department views the hospital as a basic resource.

The second is that the health department, as the public health agency of the community, is expected to provide services to hospitals just as it does to other institutions in the community. These services might be in the field of radiation, communicable disease control, or consultation on a wide variety of medical care problems—for example, rehabilitation care of the alcoholic; evaluation of the neurologically handicapped; genetic counseling, etc.—within the technical competence of the public health department. In carrying out this second function, the health department may also have legal responsibilities and law enforcement duties; these must be handled with the same discretion and judgment used in other situations of law enforcement—that is, to achieve the end of maximum indi-

vidual and community health while minimizing curtailment of individual liberties.²

HOSPITAL ENVIRONMENTAL HEALTH ACTIVITIES

Federal Level

A brief summary of the environmental health activities which apply to hospitals at various levels of government may be helpful in understanding the extent of existing relationships. At the Federal level, the U.S. Public Health Service has been given the responsibility for administering the Hill-Burton Program. Under this program, progress has been made in the development of structural and equipment standards and in medical facility design and operational techniques. The indispensable ingredient has been the willingness of community groups and agencies at local and State level to work together with the Federal agencies in a common cause.

State Level

In most instances, the State health department has been selected as the official agency with the responsibility of applying these criteria, although in a few cases the State welfare agency or some other department or commission has been designated to administer the hospital program. The State agency initially had the responsibility of surveying the adequacy of existing facilities and determining a priority schedule for granting construction funds. The Hill-Burton legislation also called for establishment of hospital licensure by participating States. This required the development of licensing standards and a continuing program of inspection to determine fulfillment of licensing requirements. Some State health agencies have effective hospital consultation programs apart from their Hill-Burton responsibilities. Institutions not involved in Hill-Burton activities are assisted on a continuing basis by these State programs, with resulting improvements in facilities and services.

Local Level

At the local level, where the most effective relationships between hospital and health agency

personnel might be expected, the current picture is not nearly so clear or encouraging. In some jurisdictions the health department, and in others the welfare department, has been charged with administering the medical care program for the indigent. However, the extent of involvement has often been limited to administering a contract program with hospitals, clinics, and individual physicians.

There are vast areas for the development and improvement of local health services. The obvious question is: What is needed to improve the relationship between hospitals and health agencies?

Specialized Personnel Training Planning and coordination of effort are basic ingredients of any joint program to insure that all facilities and personnel are used efficiently. Comprehensive health service is a community affair; it must encompass prevention, diagnosis, treatment, and rehabilitation. The health department should have personnel qualified to provide guidance to hospital management. Environmental health staff—engineers and sanitation scientists with adequate training and experience—are capable consultants on environmental sanitation problems. The environmental health factors in the institution are sufficiently complex to require extensive knowledge on the part of control program participants if they are to be effective in serving hospital needs. To develop competence in this area of environmental health, agency personnel need specialized training.

As expressed by Lawrence B. Hall and his co-workers: "... the persons carrying out the functions of planning, direction, and surveillance of the environment need more than the normal foundation of training and experience in community sanitation."³ Subjects that should be included in this specialized training include basic familiarity with the needs of institutional administrators; clinical and surgical procedures; plant engineering fundamentals and control measures for biological, chemical, and radiological agents.

In many local health departments, the best qualified sanitarian or engineer is assigned to the hospital—often, however, in combination with other duties and responsibilities which tend to reduce his effectiveness in any given area. In a few instances, hospitals have established the position of staff sanitarian, usually responsible

directly to the hospital administrator. In large institutions, this staff pattern is effective, but the majority of medium-sized or small hospitals would be unable to afford such special competence. It, therefore, becomes a logical function of the local health department to provide this form of community health service.

Infection Control Committees In some localities, the county medical society has led the way in establishing an infection control committee. Members usually have been health department personnel and the administrator, chief nurse, or physician in charge of the infection control committee within each participating hospital. Health agency representatives include the health officer and the chiefs of epidemiology or infectious disease control, laboratory services, and sanitation.

This mechanism has three distinct advantages:

1. It arouses the interest of physicians from both private and health agency positions through the machinery of their local medical society.

2. It stimulates, through hospital and health agency joint participation, a better approach to preventive control within individual hospitals. The hospital's own infection control committee is often sidetracked by work pressures or sheer inertia and ends by serving only as a sort of after-the-fact epidemiology panel.

3. It gives the medical society infection control committee a broad experience in dealing with problems that arise in a number of hospitals. This increases the competence of both private and health agency members to observe and correct potentially dangerous faults in procedures and facilities before major problems emerge and to pass on this knowledge to their colleagues.

Joint Consultation Services Another possibility is for a group of hospitals to share the services of an environmental specialist, either an engineer or sanitarian. Most hospitals are members of regional councils, county groups, or State hospital associations. Many such organizations currently provide joint purchasing, accounting, planning, and educational services. Provision for environmental consultation would seem feasible through the same mechanism with the cost factor shared by hospitals that cannot individually afford highly trained specialists.

Regulatory Activities Mention has been made of the participation of local environmental health agency personnel in certain regulatory activities.

Broader participation is not only possible but mandatory if lasting and productive relationships are to be established between the hospital and health agency. The health agency person assigned the duties of hospital environmental control should be equipped not only to carry out a comprehensive inspection of an institution but, more important, to provide the hospital staff with consultation on environmental control problems. Guiding rather than forcing compliance with necessary health provisions to protect the well-being of the public is the philosophy of most health departments. The consultant must understand the problems and also be able to present practical solutions to them. It is in this consultant capacity that public health personnel can make the most valuable and lasting contributions to the institutional field.

In the mistaken belief that surveillance and enforcement can result in better environmental control, there have been frequent pleas for microbiological standards to be applied throughout the hospital. Comprehensive standards for hospital infection control do not now exist, and there is reason to believe it will be a long while before they are established. No standard can be used as a basis for mandatory regulation until scientifically consistent evidence of the results of violations can be demonstrated. Only then are sanctions feasible.

In such well-established areas as milk and food sanitation and radiation protection, standards are applicable. Generally accepted empirical standards establishing maximum levels of microbiological air or surface contamination or conclusively proving the value of certain isolation techniques are still in the future. The best safeguard is the thorough and voluntary application of the best techniques known, i. e., those that constitute parts of a total control program which has been shown to minimize infection most effectively. The current voluntary accreditation standards, construction criteria, and health agency regulations are minimal, and it is in the nature of the hospital as a public institution to apply them without any external coercion being necessary. As a highly respected public health administrator has phrased it:

Any other approach than the fishbowl existence, in which all hospitals should live, is an invitation to mediocrity or danger and is unworthy of hospital administrators or physicians as "we" like to think of them. What person truly motivated to provide the best possible inpatient care can be threatened by external controls which are always minimal? If such people can be threatened by minimal standards, they should not be entrusted with the lives of human beings.⁴

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LEGAL ASPECTS

John F. Harty

ADMINISTRATOR

Duties and Responsibilities

THE ADMINISTRATOR of a voluntary hospital is the executive officer directly in charge of the hospital's operation. He is the general supervisor of all operations and is delegated certain powers by the governing board to meet this obligation. His primary responsibility is the successful, efficient, and orderly management of the hospital, although he may delegate authority in specific areas to various subordinate supervisors. Since the administrator is subject to the superior authority of the governing board, he is generally considered the agent of the board in supervising the hospital operation.

In governmental hospitals the administrator is usually an appointed public official. Whether he is a public official or a hired supervisor, he is directly responsible to the Federal, State, or local body which controls the health facility. In some instances he may come within the protection and obligation of civil service laws.

The administrator has only those duties which are specifically or implicitly delegated to him by the hospital's governing board. The board fulfills its legal responsibility for the conduct of the hospital by appointing an administrator and charging him with certain general management duties. The board may delegate more specific duties to the administrator by resolution, bylaw, or order and grant him the authority to discharge them. The individual policy of the board will govern the extent of the administrator's duties and authority. Following are examples of general and specific duties often delegated to the administrator.

The administrator has the general duty to oversee virtually every activity taking place in the

hospital. He must implement the policies of the board in the various departments and transmit and interpret these policies to the medical staff and other personnel. In addition, he is responsible for the promulgation of, and compliance with, all hospital rules formulated by the board or falling under its authority. He must take appropriate disciplinary action where noncompliance with hospital rules occurs, except in cases where such authority has been retained by the board or delegated to the medical staff. He also has the general duty to make a periodic report to the board on the nature of the hospital's operation during the period.

The administrator will usually be authorized to select or recommend the administrative department heads. He may then delegate to department heads the authority to select their assistants, while retaining, of course, the authority to coordinate the overall operation of the departments. Normally, the administrator is also responsible for general employment in the hospital and may fix individual salaries and wages.

The care and treatment of patients is a primary responsibility of the administrator. While he should not usurp the functions of the medical staff, he must be certain that proper admission and discharge procedures are formulated and carried out and that satisfactory standards of medical and hospital care are maintained. Also, the administrator must coordinate the operation of the departments directly concerned with patient care, such as nursing service, with the services of the attending physician. He must also see that the various adjunct facilities used in diagnosis and treatment, such as the X-ray department, pathology laboratory, and pharmacy, are functioning efficiently.

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He must assure himself that environmental protection is maintained by engineering, central service, housekeeping, laundry, and dietary departments.

In addition to those duties specifically or implicitly delegated to him by the governing board, the administrator is responsible for the execution of certain duties imposed upon the hospital by statute, regulation, or municipal ordinance. These duties include reporting vital statistics information to health authorities and furnishing communicable disease and gunshot wound treatment reports to the designated public office. He is responsible as well for assuring compliance with all licensing requirements.

Liability

As a general rule, the administrator will not be held personally liable for injuries that arise from hospital operation unless he has been personally at fault. Such fault exists when the administrator's act, which is the proximate cause of injury, is either a negligent act or an intentional invasion of a person's rights. For instance, an administrator may be liable if injury is inflicted by a negligent or intentional act of a subordinate when it is shown that the administrator was careless in hiring or supervising him. Without personal fault, the administrator is not subject to any form of vicarious liability for the wrongful acts of other hospital employees.

An administrator's wrongful act, in addition to rendering him personally liable, is likely to be the basis for the imposition of liability on his employer, the hospital. If such liability is imposed on the hospital, the hospital has the right to require the administrator to indemnify it for the amount of damages it has paid to the injured person. In actual practice the hospital rarely exercises its right of indemnification, but the administrator should be aware of this right.

The administrator (or the purchasing officer, if delegated the authority) is not personally liable on contracts which he makes on behalf of the hospital when he is acting within his authority to contract. He will be liable, however, when he enters into a contract which the hospital has not empowered him to make on its behalf. In this situation the hospital will not be bound under the contract, and the administrator or purchasing officer will be obliged to pay for any loss sustained by the other

contracting party. When the administrator has entered into an unauthorized contract, the hospital has the alternative of rejecting or ratifying it. If the hospital elects to ratify the contract, the administrator will be relieved of personal liability. Also, even though the administrator is not authorized to contract in a particular instance, he may be relieved of personal liability if he innocently believed he had such power and the hospital clothed him with apparent authority to so contract. The hospital is bound in this situation on the theory that by creating the administrator's apparent authority to contract, it cannot deny such authority to one who has justifiably relied upon it. The administrator will, obviously, be liable to the other contracting party even where he has apparent authority if he has made the contract with the intent to defraud.

The administrator or purchasing officer must be certain that the goods or services furnished by hospital contractors and suppliers are fit for the purpose for which they are intended. When they are not, the hospital has the right to take legal action against the contractor or supplier. For example, if the workmanship or materials used by a contractor do not come up to the standards set forth in the contract or to the general standards for such work in the community, the hospital may sue and recover damages. Similarly, the hospital has a right to take legal action if supplies, such as alcohol or dressings, do not conform to stated or implied quality standards. The hospital may sue for the price it paid for the deficient supplies and may also collect any damages it has been forced to pay if someone has been injured as a result of using such supplies.

The administrator may be liable civilly or criminally for the breach of duties imposed upon him by statute. For example, where the law requires a license or permit before certain acts may be performed and the administrator is required to procure it, failure to obtain the requisite certificate may lead to fine or imprisonment. In this context, the administrator also may be required by statute to make certain reports to the State. It is doubtful that a hospital administrator, in actual practice, would be jailed for failure to discharge a statutory duty of this nature, but the possibility exists. Courts ordinarily state that an agent such as an administrator will not be personally liable for the penalties imposed by statute on institutions conducting activities without the requisite license.

The same reasoning would apply to breaches of statutory duties by employees other than the administrator. For example, the pharmacist may be obliged to purchase a license for himself and the hospital to dispense drugs or the engineer may have to procure an elevator license or contract for a periodic boiler inspection. Failure to discharge these duties will render the responsible employees subject to any statutory penalties that pertain.

PERSONNEL

Hospital personnel policies must be consistent with laws and regulations pertaining to employment practices. In formulating the personnel policy, consideration must be given to Federal and State legislation dealing with matters such as wages and hours, child labor, employee safety, and the various workmen's compensation acts. It also may be necessary to comply with standards imposed by State hospital licensing acts and regulations relating to the health and qualifications of employees.

Federal and State Employment Legislation

The Fair Labor Standards Act is a Federal law that regulates the wages and hours of employees engaged in interstate commerce. States and their political subdivisions are specifically exempted; thus, hospitals operated by governmental units are not within the provisions of this law. Under a 1961 Amendment to this legislation, voluntary hospitals and practically all proprietary hospitals are exempted from the Act. Voluntary hospitals are not considered to be enterprises engaged in interstate commerce within the meaning of the law. In addition to the exclusion of voluntary hospitals, hospitals whose dollar value of services within the State in which they are located exceeds 50 percent of total services qualify for an exemption.

The provisions of the Act relating to child labor exclude States and, consequently, all governmental hospitals operated by either States or their subdivisions, such as counties or cities. Although the law contains no specific exemption for voluntary and proprietary hospitals, the Act would not appear to be applicable to them because they are neither engaged in interstate commerce nor produce goods for such commerce.

Most States have enacted legislation providing minimum wage rates and limitations upon the hours of employment. In a few States, voluntary hospitals are exempt. In many States, including some that do not exempt voluntary hospitals, exemptions under certain specified circumstances are provided for nurses, technicians, and supervisory employees. Because of the enormous amount of State legislation and the varied provisions dealing with wages and hours, it is difficult to generalize as to a hospital's obligation. The laws of the particular State must be consulted.

State child labor legislation often requires that working papers be secured before a child may be employed. It may forbid employment of minors at night and frequently provides that minors may not operate certain types of dangerous machinery. Such legislation rarely provides an exemption for voluntary hospitals, although often some exception is made as to the hours that may be worked by student nurses.

Some States have imposed a statutory duty upon employers to provide employees with a safe work place. Even in the absence of such statutes, a hospital would be liable for injuries suffered because of its negligence in the care of the premises or in maintaining defective equipment. Other statutes require the presence of certain facilities on the premises for the convenience and safety of employees. Provisions in most States require that suitable toilet facilities and restrooms be furnished. In all instances, the specific laws of the State in which the hospital is located should be consulted.

In addition to State laws requiring safety precautions, laws of the city and county in which a hospital is located may also prescribe rules to promote and safeguard the health and safety of employees. Many communities have enacted sanitary and health codes that require certain facilities or standards. In most instances these enactments do not exempt voluntary institutions.

Workmen's Compensation

Prior to the enactment of State workmen's compensation legislation, an employee injured through the negligence of his employer was required to bring a lawsuit to recover damages. This method of seeking recovery preserved for the employer certain defenses, such as contributory negligence and assumption of risk, which in many

instances barred the employee's remedy. The need for change in the law for social and public policy reasons was eventually recognized and reform came with the enactment of workmen's compensation acts. Under these acts, the question of fault of either employer or employee is not considered, and the recovery of specified amounts for an accidental injury or death depends only upon whether the accident arose out of and in the course of employment. A number of workmen's compensation acts also permit recovery for an occupational disease arising out of, and associated with, the particular employment.

Although workmen's compensation legislation is in force in every State of the union, hospitals, whether voluntary or governmental, may be treated differently in various States. For instance, some States have a compulsory statute while others have adopted elective compensation statutes. Also, nonprofit corporations and governmental agencies are excepted from coverage in some States. A reference to the law of the particular State in which the hospital is located is necessary to determine the nature and extent of coverage of the workmen's compensation law.

Civil Rights Act

Any hospital which receives Federal funds for construction or modernization, or in payment for any portion of its activities, must comply with the nondiscrimination provisions of Title VI of the Civil Rights Act. This title specifically states that: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

The Public Health Service has the primary responsibility for working with hospital and health care institutions receiving Federal aid to insure that all such facilities and their services are run on a nonsegregated, nondiscriminatory basis. Regulations relating to the provisions of Title VI were promulgated by the U.S. Department of Health, Education, and Welfare and became effective on January 8, 1965.

Under these regulations, applicants for and recipients of Federal funds must file an "assurance of compliance" form (HEW-441). This statement, when signed by an official of the hospital,

constitutes a judicially responsible undertaking to comply with the Civil Rights Act and the Department's regulations.

Hospitals in compliance with Title VI are characterized by the absence of separation or discrimination, which includes providing inpatient and outpatient care on a nondiscriminatory basis. All patients are assigned to rooms, wards, wings, or floors without regard to race, color or national origin. Employees and medical staff give services to all patients without discrimination. Staff privileges are granted and training programs are open to all. The hospital administration has notified employees and staff in writing of the hospital's policy, and has communicated this policy to the community at large, especially when it represents a change in policy.

Licensing Acts and Regulations

State hospital licensing acts and their regulations may also govern hospital personnel practices. Many of these regulations contain general language which may serve only as a guide to hospital practice, while others are explicit and state exactly what a hospital must do to observe the regulations. The more common type of regulation dealing with personnel involves physical examinations and required employee qualifications.

Because of the obvious danger to patients and other employees of diseased hospital personnel, some regulations require that a preemployment physical examination be given to all prospective employees. Also, many regulations require that an employee who has been absent with a communicable disease be certified by a physician as being in good health prior to returning to work.

suggest that technicians be registered, but registration is not a prerequisite for employment. Also, regulations dealing with nurses, dietary personnel, and medical record librarians may contain specific qualification requirements but also usually provide an alternative for the hospital. While their scope varies from State to State, the regulations indicate that the quality of personnel is of great importance under the various licensing acts.

Unions and Hospitals

Labor unions have not and do not at present constitute an extremely large factor in hospital-employee relations. However, during the last 10 years organizational activity in hospitals has become more noticeable. Union activity in the hospital field has occurred most extensively in those geographical areas in which unions have been successful in other industries. For instance, the north central region including Minnesota, Illinois, and Michigan; the Pacific region including California; and New York City, still contain the bulk of unionized hospital personnel. Over 70 percent of those embraced by labor contracts are in these regions, and any increase that has occurred in other regions has not been significant. While it is difficult to predict the extent of increased union interest in hospitals, it is likely that labor union activities will occupy more of an administrator's time than they formerly did.

The Labor-Management Regulations Act, a Federal law which defines certain conduct of employers and employees as unfair labor practice, explicitly exempts voluntary and governmental hospitals from its coverage. Proprietary hospitals also are generally outside the operation of this legislation since the effect of labor disputes in such hospitals upon interstate commerce is insubstantial.

Federal labor legislation also includes the Labor-Management Reporting and Disclosure Act of 1959. This legislation requires employers to report to the Secretary of Labor any promises made, or the making of payments and loans to representatives of labor organizations, or payments made to employees to exert influence over fellow employees concerning their right to organize and bargain collectively. Both voluntary and proprietary hospitals making such payments must file reports. Governmental hospitals are not, however, subject to these provisions. Penalties

for failure to make the required reports, or making false reports, include fines up to \$10,000 and one year imprisonment.

State labor legislation that affects union activity and the right of employees to organize unions and bargain collectively includes labor relations acts, anti-injunction statutes, laws relating to union and closed shops, and fair employment legislation.

Labor relations acts exist in several States and proscribe conduct by employer and employees that constitutes what is termed an "unfair labor practice." Many States with such legislation exempt voluntary hospitals, but proprietary hospitals are not exempt in any State act. Where State labor relations acts apply, certain conduct by an employer is prohibited. Examples include firing an employee merely for union membership, failure to bargain in good faith, dominating or controlling an employee union, or rendering financial or other assistance to one of several unions competing in an organizational attempt.

The Federal Government and many States have enacted anti-injunction acts. This type of legislation arose from the belief that courts were hampering union activities by frequently issuing injunctions against strikes and picketing. The acts set forth criteria which must be met before an injunction can be granted in a labor dispute. In some States, voluntary hospitals are specifically exempted. The administrator's primary interest in the anti-injunction statute, if one exists in his State, lies in recognizing that if such an act is applicable to a labor dispute involving the hospital, obtaining an injunction against either strikes or picketing may prove difficult.

Labor unions frequently seek union security contracts with employers. Such contracts are of two types: the closed shop contract which provides that only members of a particular union may be hired and union shop contracts which make continued employment dependent upon union membership, although the employee need not be a union member at the time of employment. By statute, 19 States have made it unlawful to enter into such contracts. Statutes forbidding such agreements are generally called "right to work" laws on the theory that they protect the employee's right to work even though he refuses to join a union. It should be noted that although such contracts may be legal in a particular State, there is no obligation imposed by law to enter into this type of contract. If, however, the particular

hospital is subject to the State labor relations act, it must bargain in good faith if the union desires such a contract.

Fair Employment Practices

Many States and cities have adopted fair employment practices legislation. Such legislation is designed to eliminate discrimination on racial, religious, and nationality grounds when hiring. Some States also forbid discrimination on the basis of age. Religious and charitable organizations, including hospitals, are occasionally exempt from such legislation. Several States and communities that have fair employment laws do not empower the agencies administering the law to enforce its orders in court and leave the operation of the law to negotiation and conciliation. In most States, however, a procedure for court enforcement is provided. Hospital employees entrusted with personnel matters should be familiar with the provisions of these laws.

TORT LIABILITY

The majority of litigation involving hospitals is concerned with tort liability. A tort is defined as any civil wrong, other than a breach of contract, which results in injury to some individual. Although tort liability covers a variety of wrongful acts, lawsuits brought against hospitals generally arise from alleged negligence of hospital employees in the care and treatment of patients or the negligent maintenance of an unsafe condition on the hospital premises. If a person is able to show that an injury has resulted from some form of hospital negligence, liability will attach and the hospital must respond by compensating the individual for his loss.

Respondeat Superior

Liability for the negligence of hospital employees is imposed under the doctrine of *respondeat superior*. This is the legal rule which requires an employer to answer for the negligence of his employees when the negligent act causing the injury occurs within the scope of employment. The imposition of liability under *respondeat superior* is justified on the rationale that the

employer has the power to control his employees and, therefore, should be responsible for their actions. It also has been said that the doctrine was adopted for the public policy reason that the burden of compensating the injured person is more easily borne by the employer than by the employee. However, the fact that the employer is liable will not relieve the employee from liability for his own negligence. The doctrine simply extends liability to include employer as well as employee.

The application of *respondeat superior* requires the presence of two conditions, namely, an employer-employee relationship and an act of negligence by the employee occurring within the scope of his employment. The employer-employee relationship exists if the employer has the right to control the physical conduct of the employee in the performance of his duties. Therefore, this relationship may exist even though there is no formal employment agreement between the parties. An employee is considered to be acting within the scope of his employment if his act was intended to be in furtherance of his employer's business and the act was closely related to the manner of performing the tasks for which he was employed or reasonably incident to his duties as an employee.

Since the hospital will be held liable under *respondeat superior* only for the negligence of employees, it is necessary to determine which of the various categories of medical personnel are classed as employees. Members of the medical staff are generally *not* considered employees of the hospital. Therefore, the hospital is rarely held liable for negligence or malpractice by a staff physician. Medical staff members are usually what the law calls independent contractors. The

compensated by the hospital, and their activities are subject to hospital control. Therefore, the doctrine of *respondeat superior* is ordinarily applicable when a resident or intern negligently causes injury to a patient. The only exception to the hospital's liability in a situation involving a resident or intern would be the so-called "borrowed servant" rule, which will be discussed later.

The doctrine of *respondeat superior* is often applied to impose liability upon the hospital when patients are injured by the negligent acts or omissions of nurses. Since relationships often vary between the nurse, hospital, patient's physician, and the patient himself, a conclusion as to the right to control the acts of nursing personnel usually determines whether the hospital or the physician is liable under *respondeat superior* or whether the individual nurse alone is liable.

Many acts of nurses, if done negligently, can result in liability for the hospital. Cases on this subject have involved application of overheated water bottles, administration of an enema of too high temperature, injection of incorrect medication, failure to catheterize a patient at the intervals requested by the patient's physician, and failure to notify hospital superiors when the condition of a patient became critical. In performing such duties the nurse is clearly acting within the scope of her employment by the hospital.

The special duty nurse is usually held to be an independent contractor rather than a hospital employee since she is ordinarily hired by the patient rather than the hospital. The hospital, therefore, is rarely held liable for the negligence of a special duty nurse under *respondeat superior*. Liability, however, may be imposed when the special duty nurse is negligent in performing administrative duties required by the hospital on the theory that the hospital rather than the patient has the right to control her physical conduct in this situation. Also, liability may result when the special duty nurse is procured and paid through the hospital.

Hospitals are, of course, also liable under *respondeat superior* for the negligence of all non-professional employees such as supportive department personnel, orderlies, elevator operators, and ambulance drivers. Also included in this category are the administrator and other administrative employees.

An important concept of tort liability is the

so-called "borrowed servant" rule. This rule states that for the purpose of applying *respondeat superior* a person may temporarily have been in the employ of someone other than his regular or general employer. For instance, a resident, intern, nurse, or technician who is ordinarily considered a hospital employee may become a temporary employee of a staff physician when performing tasks under his direction and control. When this situation exists, the physician rather than the hospital would be liable under *respondeat superior*.

However, the mere fact that a hospital employee is acting under the orders of a physician is not in itself sufficient to make him a temporary employee of the physician. When an employee negligently performs a duty that is a normal part of his general routine duties over which the hospital has control, the hospital is liable even though the employee was acting under the orders of a staff physician. Generally, if the facts of any situation disclose that the physician assumed the right to physically control the employee, the hospital as the general employer would be relieved of liability.

Corporate Negligence

Although most litigation involving hospital liability arises from situations in which an employee is alleged to have been negligent, a hospital may also be liable for the negligence of the organization itself under the theory of corporate negligence. Liability is imposed on the hospital under this theory for failure to fulfill a duty owed to anyone coming in contact with it. Instances of liability for corporate negligence include situations in which the hospital furnishes defective equipment or supplies, selects or retains incompetent personnel, or maintains its buildings or grounds in a negligent manner.

Failure to properly maintain the physical plant can result in liability under the theory of corporate negligence. Injuries from falls on slick floor surfaces have sometimes resulted in hospital liability. When the hospital has not been held liable, it was generally because of the court's reasoning that people are aware that floors in public buildings and places of business are customarily washed or waxed and that unless the work is done in a negligent manner the danger is not great. Cases which find hospital liability emphasize a duty to make the slippery condition known to those using the floors, and they take into account the physical

condition of the injured person. A waxed or wet floor is not necessarily dangerous to ordinary persons, but the physical condition of the patient may make it necessary that he be accompanied by an attendant when walking. In any event, if the floor surface is unduly slick, it could constitute negligence after the hospital has had time to detect the potential hazard.

Common sources of hospital liability are improperly maintained entrances and exits and failure to observe proper safety practices. For example, when the entrance to a clinic consisted of an inclined walk, a hospital was held liable when a crippled patient using the walk fell because of its slickness. The court clearly implied that because of the physical condition of people who use such a walk, the safety measures required of the hospital may be greater than those required of other property owners.

Allowing a sidewalk to remain icy can constitute hospital negligence, although a court has said that the care required of a hospital to keep its premises safe does not encompass cleaning steps while a snowstorm is in progress. In one case of negligence occurring on hospital premises, a chain without signs or other marking had been stretched across a sidewalk leading to an entrance no longer in use. This constituted negligence for which the hospital was held liable when a person attempting to use that entrance tripped over the unmarked chain. Similarly, a hospital was held liable when a visitor tripped over a step between the level of the sidewalk slab and that of the driveway leading to the hospital's main entrance. The accident occurred in the evening and the court held that a jury could find negligence in the hospital's failure to provide enough light to properly illuminate the area.

Doors leading to exits and elevator shafts should be plainly marked and adequately lighted. It should be anticipated that, without notice, persons will not assume that a steep drop exists just behind a door. Defective linoleum or other floor surfacing, literally almost any conceivable defect, can lead to liability. Although a particular defect is not negligence as a matter of law, in most instances the case will be presented to the jury to determine whether, in the particular circumstances, the hospital fulfilled its duty to the injured by exercising reasonable care.

As can be seen from the cases cited, most instances of hospital liability can be avoided by the

exercise of good physical plant care and the existence of a meaningful safety program in the hospital. This is one area in which suits against the hospital can be markedly reduced by care and continuing vigilance.

Often the hospital may use consultants whose reports contain recommendations on the structure or operation of the hospital. These recommendations raise legal issues only to the extent that it may constitute corporate negligence to ignore them. If a report contains simple safety recommendations and the hospital ignores them at its peril, it would probably be liable for any injury that occurred even if it had never received a report. However, such a report does provide evidence that the hospital did know of a condition of potential risk and did nothing to alleviate it.

Governmental Immunity

A hospital operated by a unit of government may be immune from lawsuits arising from employee negligence. The immunity of governmental units is derived from the English common law doctrine of sovereign immunity. This doctrine simply provides that the sovereign power cannot be sued without its consent. The idea behind sovereign immunity was that the king could do no wrong and was thus not subject to suit for wrongs committed by his subordinates. This doctrine to-day forms the basis of sovereign immunity.

Federal and State governments are immune from liability arising from the negligence of their officers, agents, and employees.

By enactment of the Federal Tort Claims Act in 1946, Congress partially waived the sovereign immunity of the Federal government. It is now possible, subject to certain limitations in the Act itself, to bring suit against the Federal government to recover for negligent injuries caused by its employees. The Act applies to injuries caused by negligence of employees of Federal hospitals, including those operated by the Veterans' Administration, Army, Navy, Air Force, and the Public Health Service.

The concept of sovereign immunity also has been extended to political subdivisions of the State when they are engaged in governmental functions, based on the reasoning that since political subdivisions are arms of the State, they should be afforded the same immunity. There-

fore, hospitals operated by cities, counties, or special authorities are also included within the scope of governmental immunity.

State hospitals are normally classified as instrumentalities of the State and are considered as engaged in the exercise of the State's sovereign functions. The doctrine of sovereign immunity is, therefore, applicable and provides a defense to an action against the State for the negligence of employees of a State hospital. Some States, such as New York, have waived immunity from suit by statute; others have limited immunity when a State hospital carries liability insurance. However, in the great majority of States, sovereign immunity is a complete defense to suits for negligence occurring in State hospitals.

In the absence of statutes waiving immunity, political subdivisions such as county and municipal governmental units are ordinarily immune from tort liability when engaged in a governmental rather than a proprietary function. A proprietary function is one which limits its benefits to persons within the geographical limits of the subdivision, as opposed to a governmental function which benefits the public as a whole regardless of geographical boundaries. Therefore, should the operation of a hospital by a county or municipality be deemed governmental rather than proprietary, immunity will attach. In determining whether the operation of a hospital is a governmental or proprietary function, the factors considered include whether the county or municipality was required to operate the hospital under a statutory duty and whether the hospital admits paying patients in addition to those unable to pay. These factors may determine in some States whether or not immunity will apply. For instance, if a municipally operated hospital were merely permitted by State statute, rather than required, to operate as a hospital or if it were to admit paying patients, some courts would hold these factors sufficient to constitute a proprietary function.

The doctrine of governmental immunity has been made the subject of both judicial and statutory exceptions in many States, and the reasoning upon which it rests has been subject to intense reexamination in recent years. Several jurisdictions have abrogated the doctrine completely by judicial decision. If the present trend continues, governmental bodies in the foreseeable future will probably not enjoy immunity from tort liability.

Charitable Immunity

The nonprofit organization as a corporate entity is considered by law a legal person and as such is ordinarily responsible for its own acts and those of its employees. In approximately half of the States, however, the law provides at least partial protection to voluntary nonprofit hospitals and other charities under the legal doctrine of charitable immunity. Thus, hospitals organized and conducted for a charitable purpose will be relieved of liability for injuries resulting from the negligence of the hospital or its employees. The only requirement which the hospital must fulfill for the doctrine to apply is that it be charitable in the full sense of the word. Generally, those hospitals referred to as voluntary nonprofit hospitals meet this requirement, since they are organized in such a manner that no benefit inures to individuals and any profits are completely devoted to the charitable purpose of the hospital.

The doctrine of charitable immunity is subject to various limitations. For example, if a court determines that the activity causing the injury is commercial in nature, the doctrine will not apply even though the revenue of such activity is devoted to a charitable use. Examples of activities which might be considered commercial are snack bars, gift or thrift shops, and cafeterias. Certain factors, such as whether the facility was made available to the general public and conducted for the purpose of obtaining revenue, are considered in determining the nature of the activity.

Some States refuse to apply charitable immunity if the hospital has liability insurance. Recovery by an injured person in these States is allowed under the theory that hospital funds will not be diverted from a charitable purpose since the insurance company will pay for the injury. In other States a distinction is drawn as to the status of the injured person. Courts in these States may apply the doctrine if the injured person was a patient at the time of the injury on the theory that the patient waives his right of recovery by accepting the benefits of the charity. Under this theory, if the injured person is anyone other than a patient—a hospital visitor, for example—recovery would be allowed if negligence is present.

Several States permit recovery against a charitable institution if an injury results from corporate or administrative negligence of em-

ployees. Immunity may be denied, therefore, in instances where there has been negligence in the selection or retention of personnel, failure to instruct employees, supplying of defective equipment, or violation of a statutory duty.

Although the charitable immunity doctrine is subject to various limitations, it is still of significance in many jurisdictions. There is, however, a discernible trend toward abolition of the doctrine, and in recent years it has been abandoned in several States by judicial action.

HOSPITAL LICENSURE

Prior to 1946, not more than a dozen States had in effect any comprehensive laws relating to the licensure and operation of hospitals. The Hospital Survey and Construction Act,* referred to as the Hill-Burton Act, with its requirements that participating States adopt legislation requiring minimum standards, greatly encouraged the enactment of licensure laws. Although a few States have limited their licensure laws to only those hospitals built under the Hill-Burton Act, most of the present laws apply to all general hospitals, both nonprofit and proprietary. Since 1946, practically every State has enacted legislation providing for licensure of hospitals.

Generally, State licensing laws are based upon the power of the State to provide for the health, safety, and welfare of its citizens and are directed toward providing minimum standards for the operation of hospitals. The usual licensing law vests authority in a department of State government, or a newly created State agency, to administer and enforce the law and promulgate appropriate regulations. Although the various State laws and regulations differ in their particulars, provisions are made for the responsible department or agency to inspect hospital premises and enforce State regulations by withholding approval for or revoking a license, withholding State aid, or commencing legal proceedings to enjoin violations. In some States, a violation of the regulations is a misdemeanor, punishable by fine or imprisonment.

The coverage of hospital regulations is so extensive, with so many detailed requirements, that a comprehensive analysis is beyond the scope of a summary of fundamentals. Briefly,

licensing regulations generally set forth specific requirements relating to the physical plant, nursing and surgical services, and facilities such as laundry and housekeeping. Even in the absence of provisions in the hospital licensing regulations, hospitals may be subject to State laws and local ordinances relating to sanitation, equipment, fire protection, safety devices, and building regulations. Thus, the hospital must comply with the standards of safety and cleanliness ordered by the local fire marshal and public health officer. Not only is it a misdemeanor to fail to comply, but such failure is almost conclusive evidence of negligence when the failure causes injury to a patient, employee, or visitor. This latter point is especially important. If at trial, it is shown that such a standard existed; that it was in a State statute, local ordinance, or regulations issued under either; that the hospital failed to comply, and that someone was injured as a result of this failure, hospital liability is almost inevitable.

INSURANCE

One of the most important responsibilities of a governing board is the preservation of hospital assets. This responsibility is customarily satisfied by a comprehensive insurance program designed to guard against loss arising from hospital operation. Like any complex organization, hospital assets are threatened by accidental destruction, theft, liability resulting from the wrongful acts of hospital employees, and other recognized hazards. Because of the specialized knowledge required to interpret the ordinary insurance policy and the

2. Vandalism and malicious mischief.
3. Water damage.
4. Sprinkler leakage.
5. Earthquake.
6. Steam boiler and machinery.

Policies providing protection for specific items of hospital property may also be obtained. Coverage is available for items such as elevators, plate glass, automobiles, radium, paintings and other art objects, and surgical, diagnostic, or therapeutic equipment.

B. Theft Insurance

Theft insurance may be generally divided into two categories: theft by employees and theft by outsiders.

The following are the major forms of theft insurance:

1. Individual fidelity bonds or blanket bonds—covers financial loss by the dishonest acts of employees.
2. Safe burglary protection.
3. Money and securities—covers financial loss from destruction, however caused, of money and securities.
4. Office burglary and robbery.
5. Forgery bonds.

Some insurance companies may offer comprehensive coverage in one policy.

C. Hospital Liability Insurance

Liability insurance is designed to protect the hospital's assets by providing for payments to those persons who have been injured as a result of some negligent or wrongful act for which the

hospital corporation is responsible. The following types of coverage are available:

1. Automobile—covers any liability imposed by law arising out of the ownership, maintenance, or use of ambulances.
2. Elevator—covers injuries resulting from the use of the hospital's elevator system.
3. Professional—includes malpractice, error, or mistake in rendering or failing to render medical, surgical, dental, or nursing treatment. It may also cover administrative employees.
4. Public liability—covers liability for injuries sustained by patients, visitors, and others caused by a defective condition on the hospital premises.
5. Power plant—covers liability arising out of the ownership, operation, maintenance, or use of a power plant or power-producing equipment.
6. Product—covers liability arising out of products manufactured, sold, handled, or distributed by the hospital. This would be applicable to the hospital pharmacy, cafeteria, gift or coffee shop.
7. Workmen's compensation—covers the hospital's responsibility to an employee injured in the course of his employment. This would be applicable to hospitals that are subject to the workmen's compensation statute of their particular State.

The presence of liability insurance may affect the application of the charitable immunity doctrine. As previously noted, some States do not apply the doctrine when the hospital has liability insurance on the theory that the assets devoted to charitable purposes will not be disturbed when insurance proceeds are present.

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★ U.S. GOVERNMENT PRINTING OFFICE: 1961—O 341-341

HOSPITAL AND MEDICAL FACILITIES SERIES

"Publications of the Division of Hospital and Medical Facilities," Public Health Service Publication No. 930 G-3 (Revised 1966), will be provided upon request. For a free single copy, write to:

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Publications must be ordered by their complete title and publication number.